April 30, 2008
ANNE ARUNDEL COUNTY MENTAL HEALTH
HOSPITAL DIVERSION PROGRAM
ANNUAL OPERATIONS REPORT

I. PURPOSE: to assess, stabilize, and treat persons with serious mental disorders who need immediate stabilization and engagement as a first step to recovery from mental illness and/or substance abuse.

II. STRUCTURE: Expand the county psychiatric crisis system by providing a Mobile Crisis Diversion Team (DT):
   a. To provide services to mental health and co-occurring consumers who are uninsured and present at local emergency departments for publicly funded psychiatric hospitalization.
   b. To use licensed mental health professionals to perform on-site psychiatric assessments in the emergency department of each hospital.
   c. With the patient's written consent, to link, obtain, or purchase community based behavioral health services, purchase inpatient care, or authorize admission to a state psychiatric hospital.
   d. To support consumers in their effort to obtain appropriate entitlements, such as Medical Assistance and Primary Adult Care,
   e. To be available from 8:00 A.M. to 8:00 P.M., Monday through Saturday, to ensure that behavioral health services are offered in the least restrictive environment by arranging for, providing, or purchasing appropriate clinical care.

III. METHOD: When any person is assessed by the Anne Arundel Medical Center (AAMC) Emergency Department (ED) Psychiatric Clinician as needing a State Hospital Admission:
   a. The ED staff calls the Diversion Team. During normal operating hours the Diversion Team (DT) is to arrive at the ED within 60 minutes of the call.
   b. The DT provides a consultation which considers alternative community services that could be purchased for the person, including, but not limited to:
      - Same or next working day psychiatric outpatient services.
      - Same or next working day psychiatric co-occurring disorders outpatient services.
      - Residential crisis services.
      - Residential substance abuse services licensed or approved by the Maryland Alcohol and Drug Abuse Administration.
   c. If State Hospitalization is indicated, the DT may authorize purchase of a public/private partnership psychiatric in-patient bed (PPP Bed), as approved by MHA's Administrative Service Organization; or it may direct admit to Springfield Hospital Center (State Hospital System).
   d. The Diversion team personnel are cross-trained by the Department of Health in ASAM addiction assessment.

e. The Department of Health co-funds substance abuse treatment if criteria are met.
f. The program follows the patient for 30 to 60 days and arranges mental health and substance abuse treatment at the appropriate level of care. Transportation to the first appointment is provided to insure a high "show" rate and payment to the providers. Transportation is also arranged for periods between services and follow-up visits.

IV. BASELINES: In FY06 there were:

A. 335 State Hospital admissions and Purchase of Care (In-patient) episodes from Anne Arundel Medical Center (AAMC) (average of 28 per month)
B. 4,441 persons evaluated for psychiatric reasons at the two hospital's emergency departments. AAMC evaluated 1,850.
C. 410 State Hospital Admissions from Anne Arundel County, using 35,614 bed days.

V. ACTIVITY: from April 15, 2007 to April 15, 2008, there were:

A. A total of 388 persons reviewed face-to-face by team (average 32 per month, target 38).
B. 39% diverted to community services (target 30%).
C. State Hospital admissions from AAMC were six persons, only one direct admit.
D. Admissions to PPP Beds were 230 persons, using 2016 authorized bed days.
E. An average cost of in patient care per episode of <$4,000 (target <$5,000)
F. The number of repeat users was 51 (15.6%).
G. Co-occurring substance abuse: 67%.
H. Homeless: 44%.
I. Primary diagnoses are Major Depressive Disorder and Bipolar (65.9%)

VI. IMPACT:

- State Hospital admissions down from 410 in FY06 to 215 in FY07 (down 48%).
- State Hospital bed day use down from 35,614 to 31,777 in FY06 to FY07 (Down 11%).
- LOS in purchase (PPP) beds is 8.77 days (target <9).
- Admissions to Springfield Hospital from AAMC ED is down >90%.

VII. DISCUSSION:

- Face-to-face consultations have resulted in 39% being diverted to alternative community services. Of those diverted, the largest number (53%) goes to substance abuse services with mental health also needed. This is not unexpected due to 67% being diagnosed with co-occurring disorders. Integration of the services

has resulted in an unusually high amount of time being spent on service coordination, transporting persons, and telephone follow-up.

- Surprisingly few (3%) of the community diversions went to Crisis Beds. There are two contributing factors to this low utilization: 1) Crisis Bed usage is highly unpredictable and comes in surges, so beds are often not available when needed; 2) The available beds are out of County, making logistics difficult and time consuming for the team and possibly reducing use.
- Most of the interventions involve a very sick population needing multiple interventions, sometimes simultaneously, and the severity of problems may contribute to the lack of entitlements. Most persons appear to be eligible for the Public Mental Health System (PMHS) but are so disordered they have never applied for or have dropped off entitlements and thus show up as "uninsured". The lack of case management resulted in a huge amount of clinical time being devoted to linking and follow-up.
- The high number of co-occurring diagnoses drives people to the EDs as a place to get immediate intervention, particularly for "precomtemplating" substance abusers with mood disorders who threaten suicide if treatment is not rendered immediately. Access to ongoing psychiatric care may prevent persons from repeatedly using the ED instead of less outpatient treatment.
- There appears to be a significant drop in the time a person spends in the ED. One staffer says "it is now hours verses days".
- Persons with multiple episodes have up to 12 times the average cost of single-episode persons. Strategies for managing this subset are being examined.
- The longer the program goes on, the lower the percent of diversions. This was found in Montgomery County as well. It is theorized that there are numerous people at first who will do well with intensive outpatient care. Once they receive ongoing treatment they will stabilize. This leaves a remaining population of higher need, less compliant, more complex persons whose needs may ultimately indicate longer term stabilization.
- The program has directed more attention to co-occurring disorders and complete assessment which may result in stabilization in the community by integrating treatment and funding. A secondary gain is realized through working cooperative arrangements between the substance abuse and mental health provider communities. It has been extremely helpful to have a local Co-occurring Disorders Steering Committee focused on service integration, training, and coordination.
- Th program provides an integrated approach to working with the special needs of those who are homeless.

VIII. CONCLUSIONS:

- Hospital Diversion is possible for 25-30% of persons routinely deemed in need of State Hospitalization, usually based on a lack of insurance and not on clinical conditions.
- Purchased beds are generally shorter duration if community services are prioritized for this population. The shorter stays require more access to and integration of outpatient follow-up for mental health and substance abuse.
- More than two thirds of the evaluees have major psychiatric diagnoses and require medication treatment and follow-up.
- Access to ongoing mental health and substance abuse outpatient treatment resulted in longer interventions by the DT.
- Co-occurring Substance Abuse is the expectation, not the exception, and treatment for both disorders must be addressed to safely and successfully divert.
- Multiple users rapidly and dramatically escalate in cost. A study of interventions for this group will be helpful. ACT may be a viable follow-up.
- Additional emphasis on dealing with the after-care needs of the homeless who find their way back to the ED for shelter and refuge would strengthen the system.
- Providing assistance with entitlements offers consumers better access to long term care
- There is evidence of overall cost savings.
- Partnerships between substance abuse and mental health providers and managers are both possible and vital. Co-funding is cost effective.
- Ongoing training improves performance and outcomes.

IX. FINANCIAL IMPLICATIONS:

- FY 2007 original estimates were to evaluate an average of 28 persons per month at AAMC. The twelve-month average is 32.
- The total annual cost of operations to MHA was estimated at $2,178,000. The annualized cost at current rates would be $2,172,478.

X. FUTURE EXPECTATIONS

- The program will expand to include Baltimore Washington Medical Center effective June 1, 2008.
- Resources are being assigned to focus on coordinating entitlements with the goal of obtaining PAC and MA for these consumers.

- The program is working to expand the community alternative service base and access tp in-patient psychiatric facilities. New partnerships are in place with Upper Shore Hospital and Bon Secours Hosptial.
- The Program is offering consulting and State Hospital Placement support to the Five-County Region, including Calvert, Charles, St. Mary's and Prince George's and Howard Counties.
- The program is seeking funding sources to increase Diversion Team resources to create a comprehensive system that has the capacity to serve all of the uninsured in Anne Arundel County.